VAN AMEYDE UK LTD

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ACCIDENT & ILLNESS CLAIM FORM

IMPORTANT: PLEASE READ CAREFULLY

Please answer all questions in FULL and in BLOCK CAPITALS.
Section (A) has to be completed by YOU. Please ensure that you sign the Claim Form, and enclose your Certificate of Insurance / Policy Schedule
Section (B) has to be completed by YOU, after you have read the notes explaining your rights under the Access to Medical Reports Act 1988.
Section (C) has to be completed by your DOCTOR. Any charge for completion of this section is your responsibility.
Please ensure that all relevant questions are answered, and that all appropriate sections and boxes are completed.
Failure to do so may delay the processing of your claim.
The form when fully completed must be returned to the Insurance Broker, who will forward it to Van Ameyde UK Limited.

SECTION A; To be completed by the Claimant.

If unable to apply personally, this form may be completed on behalf of the claimant

Certificate / Policy Number

Surname:

Title:

Date of Birth

First Name:

Home Tel No::

Address:

Mobile No:

Occupation:

Post Code:

Are you still totally incapacitated as a result of your accident/illness? YES NO

Date from which you have been unable to attend your normal occupation.

If NO to, the above please provide the date of your return.

Have you ever suffered from this or any connected disability prior to the insurance commencing?

YES NO

(Part of duties)

(All of duties)

If YES to the above, please provide full details including dates.

SECTION A: (continued)

PLEASE PROVIDE FURTHER DETAILS OF THE NATURE OF YOUR DISABILITY AS APPROPRIATE

ACCIDENT
Date and time of Occurrence:

ILLNESS
Date upon which symptoms first appeared:

Please describe the circumstances leading to your accident.

Please describe the cause of your illness.

Please provide the name and address of the Doctor who attended you, and the name and address of your usual Doctor if different:

Attendant Doctor

Usual Doctor

Have you been confined to hospital?
If so please confirm admission and discharge dates

When did you first seek medical attention in relation to your disability?

What is your expected date of return to work?

Full name and address of employer at the commencement of disability

Have you previously claimed benefits under this insurance? If YES please provide full details.

YES ☐ NO ☐

Are you covered for benefits for your disability under other Insurance? If YES please provide full details.

YES ☐ NO ☐

I certify that the foregoing statements are correct. I understand that some of the information I have provided will be made available to other Insurers for Underwriting and Claims Handling purposes. I consent to the seeking of information from other insurers to check the answers I have provided, and I authorise the giving of such information.

SIGNATURE:..**DATE:**..

SECTION B: To be completed by insured person

YOUR RIGHTS - PLEASE READ CAREFULLY

ACCESS TO MEDICAL RECORDS AND REPORTS

Your consent is needed before we can apply for a medical report from your doctor, or other medical practitioner. This is governed by the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (made under the Northern Ireland Act 1974) and the Data Protection Act 1998.

In the event that you do not consent we may be unable to process your claim, or continue with benefits for a claim already in existence. If you do consent then you have a choice whether or not to see the report before your doctor, or medical practitioner, forwards it to us.

If you indicate below that you wish to see the report you will have twenty-one (21) days after you have received our notification in which to contact your doctor, or other medical practitioner. If you indicate below that you do not wish to see the Report but later change your mind, you are entitled to request a copy directly from your doctor, or other medical practitioner, for up to six (6) months after it has been sent to us. If you are supplied with a copy of the Report your doctor, or other practitioner, is entitled to charge you a reasonable fee to cover costs. In addition, if your doctor, or other medical practitioner, spends time with you discussing your Report there is an additional entitlement to charge a fee to cover the time involved as this would not fall within the NHS Terms of Service.

Your doctor is not obliged to let you see any part of the report if it is felt it would cause you harm, would indicate his intentions towards you or would reveal the identity or details of another person who is not a professional involved in your care. Your doctor, or other medical practitioner, will inform you if this applies to sections of your Report and you may see the remaining parts. If the whole Report is affected then it will not be forwarded to us without your further consent.

You are entitled to write to your doctor, or other medical practitioner, and request that your Report be amended if you consider it, or any part of it, to be incorrect or misleading. If your doctor, or other medical practitioner, is not prepared to amend your Report, a statement of your views can be attached to it.

Please tick the appropriate box, complete the form hereunder (where applicable) and return it to us.

I wish to see the Report before it is sent ☐

I do not wish to see the Report before it is sent ☐

Signed: ....

Print Name:..

Date of Birth: ....

Address:..

....

....

Post Code: ....

Date of Signing: ....

Please Complete

MEDICAL PRACTITIONERS

DETAILS Name: ....

Address:..

....

Post Code: ....

HOSPITAL DETAILS

Name:..

Address:..

....

Post Code: ....

DATA PROTECTION ACT 1988

Van Ameyde UK Ltd, will fairly and lawfully collect and record personal information that is supplied within and as a result of this form. We shall share information with your underwriters and their agents and in certain cases, with other underwriters to help detect and prevent fraudulent claims. We require your consent to process information in this way and by completing and signing this form you are explicity providing that consent.

SECTION C: To be completed by your DOCTOR

The claimant must obtain, at his or her own expense, the following Certificate from a duly qualified and Registered Medical Practitioner.

Are you the usual Medical Attendant of the claimant? YES ☐ NO ☐

If YES how long have you been so?

On what date did you first attend upon claimant for his/her present disability?

On what date did you first sign claimant as unfit for work?

Please confirm the nature of the illness or injury sustained, together with details of the precise diagnosis and treatment being given.

Has the claimant suffered from this or any other associated complaint, prior to this period of disability? YES ☐ NO ☐

If YES please give dates and types of treatment:

At the time of the accident or commencement of sickness was the claimant suffering from any other illness or disease? YES ☐ NO ☐

If YES please give details with medication prescribed and advise whether this will retard recovery of present disability.

Is the disability due to self-inflicted injury, consumption of alcohol, drug abuse, childbirth, pregnancy, abortion, or venereal disease or other sexually transmitted disease or HIV related illness including Acquired Immune Deficiency Syndrome (A.I.D.S.) or A.I.D.S. Related Complex (A.R.C.) YES ☐ NO ☐

If YES please provide details:

Is the claimant presently confined to the house? YES ☐ NO ☐

Has the claimant been confined to hospital? YES ☐ NO ☐

If so please confirm admission date / discharge date

When do you expect the claimant to return to work

Has the claimant been confined to the house since commencement of disability? YES ☐ NO ☐

If the claimant has already returned to work please state the date and whether he/she was able to return to all, or just part of his/her duties.

DECLARATION BY DOCTOR:

I confirm that the claimant is/was under medical attention, and was totally prevented from working for remuneration or profit from his/her normal occupation from: .... to: ....

Doctors Official Surgery Stamp

Doctors Signature:

Doctors Name:
(BLOCK CAPITALS)

Date: